

ATTACHMENT 7

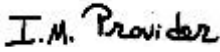
Sample Prior Authorization Request Form (PA/RF) for exceptional supplies

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE ? ICN		AT	Prior Authorization Number 1234567			
SECTION I — PROVIDER INFORMATION						
1. Name and Address — Billing Provider (Street, City, State, Zip Code) I. M. Williams 1 W. Williams Anytown, WI 55555		2. Telephone Number ? Billing Provider (XXX) XXX-XXXX	3. Processing Type 139			
		4. Billing Provider's Medicaid Provider Number 12345678				
SECTION II — RECIPIENT INFORMATION						
5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555				
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F				
SECTION III — DIAGNOSIS / TREATMENT INFORMATION						
10. Diagnosis — Primary Code and Description 518.81 Acute respiratory failure		11. Start Date — SOI	12. First Date of Treatment — SOI			
13. Diagnosis — Secondary Code and Description V55.0 Tracheostomy		14. Requested Start Date 12/01/03				
15. Performing Provider Number	16. Procedure Code	17. Modifiers 1 2 3 4	18. POS	19. Description of Service	20. QR	21. Charge
	E1399		31	Trach care kit BID	60	XXX.XX
	E1399		31	Trach suction catheter/every shift	90	XXX.XX
	E1399		31	Trach tube holder every 3 days	10	XXX.XX
	E1399	RR	31	Compressor	30	XXX.XX
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.					22. Total Charges	XXX.XX
23. SIGNATURE — Requesting Provider 					24. Date Signed MM/DD/YY	
FOR MEDICAID USE		Procedure(s) Authorized:		Quantity Authorized:		
<input type="checkbox"/> Approved		Grant Date		Expiration Date		
<input type="checkbox"/> Modified — Reason:						
<input type="checkbox"/> Denied — Reason:						
<input type="checkbox"/> Returned — Reason:						
SIGNATURE — Consultant / Analyst				Date Signed		